Medical Exemption Procedures (Alternate Portfolio Only)

Instructions for applying for a Medical Exemption

It has been the intent of the Kentucky General Assembly that **all** students participate in the assessment and accountability components of KRS 158.645-KRS 158.6455.

The few exceptions currently allowed include those students who cannot complete either the regular or alternate assessment components even with the allowable accommodations or modifications due to medical or mental health conditions.

It is important to note that a student's disability alone cannot be used as the justification for requesting a medical exemption. Assessment is mandatory regardless of student's disability and should incorporate accommodations and modifications as appropriate.
If an accountable school feels that participation in the state-required assessment would be detrimental to a student's physical, mental, or emotional well-being, the school **must** complete a Medical Exemption Form for KY Alternate Assessment Program, obtain a physician's signature, and return the original signed form to KDE and a photocopied form to KAP:

Original Form to:
Kathy Moore
Office of Assessment & Accountability
18th Floor Capitol Plaza
500 Mero Street
Frankfort, KY 40601
(502) 564-4394
FAX (502) 564-3249
kathy.moore@education.ky.gov

Photocopied Form to:
Jean Clayton
KY Alternate Portfolio
Suite #722
One Quality Street
Lexington, KY 40506-0051
(859) 257-7672
FAX (859) 323-1838
jclayto@uky.edu

DEADLINE for submitting a request for a medical exemption for The KY Alternate Assessment Program is JANUARY 15, 2006.

The request for a medical exemption is reviewed by each of the offices respectively. Incomplete forms will be returned for more information. Completing a request for a medical exemption does not guarantee approval. When a medical exemption is denied, the student is required to submit a portfolio. Failure to submit the portfolio will result in an incomplete non-participating score. The Alternate Portfolio is a collection of evidence of on-going instruction across multiple school years, versus an on demand assessment, therefore medical exemptions for the Alternate Portfolio are very rare. The presence of a disabling condition(s) alone cannot be a reason for granting a medical exemption. A student would be exempt from assessment only if a persistent medical or mental health condition requiring extensive hospitalization compromised the delivery of classroom or home/hospital instructional services.

Some physicians may be reluctant to complete the form requesting a medical exemption for the KY Alternate Assessment Program because of patient privacy concerns. Included is a Model Authorization Form under HIPAA (Health Insurance Portability & Accountability Act of 1996), designed by the KY Medical Association. This form can be used to legally protect the physician when release of patient's protected health information is being made to anyone for a purpose

other than treatment, payment, or health care operations. The form can be adapted to meet the needs of a particular situation and a particular physician's practice.

See the following pages for the KY Alternate Assessment Program Medical Exemption Form and the Model Authorization Form under HIPAA.

KY Alternate Assessment Program Medical Exemption Form
2005-2006 Commonwealth Accountability Testing System

Section 1 – *School/District use only. Please print or type.*

A. Exemption for: (*This form is for **ALTERNATE ASSESSMENT** only. Please make sure that **all** information is filled out. Submission of requests DOES NOT guarantee approval.)*

_____ Alternate Assessment Portfolio

B. Student information

_____ _____

Student's Last Name First MI Student's Grade

_____

District and School Student Attends

Attending District/School Number

_____

Accountable District and School for Student (if different from above)

Accountable District/School Number

Has the student been or is the student currently on Homebound Instruction? _____Yes _____No

_____

Date of Diagnosis or Start of Illness

_____ _____

District Assessment Coordinator Signature (**REQUIRED**) Date of Request

Section 2 –*Physician use only. Please print or type.* (*Attach additional pages if necessary.)*

A. Describe, in detail, this student's medical or mental condition. *(Please avoid the use of abbreviations.)*

B. Would participation in the state required assessment adversely affect the physical or mental condition of this student? If yes, please explain. (*This alternate assessment can be administered over time in a school, hospital, or home setting finding optimal times to develop entry content with the student.)*

_____YES _____NO

I understand my signature indicates that I believe participation in the state-required assessment would be detrimental to this student's well being.

_____ _____ _____

Print or Type Doctor's Name Doctor's Signature Date

Section 3 – *I give permission to release my child's pertinent medical information to the school district's representative. KY Department of Education and the testing contractor (CTB/McGraw Hill) for the purpose of applying for a medical exemption from the 2004 state required assessment. I understand that pursuant to Public Law-104-191, all parties will keep this information confidential.*

_____ _____

Parent or Guardian Signature Date

*NOTE: Completion of this form ***does not*** guarantee approval

Model Authorization Form under HIPAA*

This form should be used when release of a patient's protected health information is being made to anyone for a purpose other than treatment, payment, or health care operations. The form should be adapted to meet the needs of a particular situation and a particular physician/ practice. Releases in which the form will be needed are discussed in the KMA HIPAA material regarding Authorizations.

I, _____, hereby authorize _____ to use and/or disclose my
Name of Patient Name of Physician/Practice
protected health information described below to_____.
Name of Person or Entity to receive the information

My protected health information will be used or disclosed upon request for the following purposes[please indicate and explain each purpose]:

_____

_____

This authorization for use and/or disclosure applies to the information described below [mark those that apply]:

□ Any and all records in the possession of _____, including mental health,
Name of Physician/Practice
HIV, and/or substance abuse records. [Cross out any item you do not authorize to be released.]

□ Records regarding treatment for the following condition or injury _____
on or about _____.

□ Records covering the period of time_____ to _____.

□ Other [please specify-include dates]_____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to

_____.
Name and Address of Contact Person at the Practice

I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that _____
Name of Physician/Practice
may not condition treatment or payment on whether or not I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on [please list a specific date or event] _____.
I certify that I have received a copy of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

* The source of this document is the Kentucky Medical Association.